



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

November 18, 2011

Mr. Bruce Bodemer, Administrator
Centers For Living And Rehab
160 Hospital Drive
Bennington, VT 05201

Provider #: 475029

Dear Mr. Bodemer:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **October 3, 2011**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN".

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OCT 26 2011

PRINTED: 10/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475029		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/03/2011	
NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 160 HOSPITAL DRIVE BENNINGTON, VT 05201			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	INITIAL COMMENTS			F 000			
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>The Division of Licensing and Protection conducted an unannounced on-site complaint investigation on 10/3/11. A regulatory violation was identified.</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well being for one resident related to pain management, comfort, and identifying and addressing barriers to managing pain. (Resident #1). Finding includes:</p> <p>Per record review of the Medication Administration Record (MAR) and Nursing Pain Assessment, and confirmed during an interview with the Director of Nursing (DNS) on 10/3/11 at 12:00 PM, Resident #1 was medicated with Dilaudid 2-4 milligrams approximately every four to five hours from the date of admission on 7/9/11 until discharge to the Hospital on 7/13/11. Prior to receiving the Dilaudid, Resident #1 consistently rated his/her pain from 8 to 10 on a</p>			F 309	<p>F309 – Resident no longer resides in this facility.</p> <p>Residents admitted to this facility in the last 7 days have an interim care plan addressing pain, if applicable, done within 24 hours of admission.</p> <p>Residents admitted to CLR will have a pain management care plan written within 24 hours of admission, if pain management is part of their care</p> <p>A computer audit will be conducted by nurse manager/designee in the morning of the previous days' admissions to assure that an interim care plan has been completed. Line staff will be re-educated on the admission care plan process.</p> <p>Interim care plans (those done within 24 hours of admission) will be audited by DNS and Administrator for 3 months with results reported to the CLR Quality Committee.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 scale of 10 every 4 hours daily from 7/9/11 to 7/13/11 (a rating of 10 is the highest level of pain). Per interview on 10/3/11 at 1:11 PM, the DNS confirmed that Resident #1 did not have an interim plan of care on 7/9/11, 7/10/11 and 7/11/11 to address pain management, comfort, and identify and address barriers to managing pain.	F 309	<i>adjusted P.O.C</i> <i>11/3/11</i> <i>Dalton Cumb</i>		

BB

10/21/11